



# PLAN DETAILS & PREMIUMS

[www.corsana.com](http://www.corsana.com)

# EXTENDED HEALTH CARE PLANS

Corsana offers a wide range of extended health care plans to fit your needs.

	† GUARANTEED ANYTIME		† GUARANTEED IN A 60-DAY OPEN WINDOW		MEDICALLY UNDERWRITTEN
	Essential	Essential Plus	Complete	Complete Plus	Optimum
Co-Insurance (Drugs)	X	80%	80%	80%	90%
Prescription Drugs	X	\$750	\$1,000	\$2,500	\$10,000
Co-Insurance (EHS)	80%	90%	100%	100%	100%
Travel Benefit	\$1,000,000 (100%)	\$1,000,000 (100%)	\$1,000,000	\$1,000,000	\$1,000,000
Trip Cancellation	\$5,000 (100%)	\$5,000 (100%)	\$5,000	\$5,000	\$5,000
Hospital Accommodations	X	X	\$3,000	\$3,000	\$5,000
Private Duty Nursing/PSW	\$1,500	\$2,500	\$5,000	\$5,000	\$5,000
Psychologist/ Master of Social Work /Psychotherapist	\$400 combined	\$400 combined	\$400 combined	\$500 combined	\$500 combined
Speech Therapist	\$400	\$400	\$400	\$500	\$500
Physiotherapist	\$400	\$400	\$400	\$500	\$500
Podiatrist/Chiropracist	\$400 combined	\$400 combined	\$400 combined	\$500 combined	\$500 combined
Massage/Chiropractor/ Osteopath/Naturopath/ Acupuncturist/Dietitian/ Occupational Therapist	\$400 combined	\$400 combined	\$400 combined	\$500 combined	\$500 combined
Vision	\$100 (100%)	\$100 (100%)	\$150	\$200	\$250
Eye Exam	\$65 (100%)	\$65 (100%)	\$65	\$65	\$65
Audio	\$300 (100%)	\$300 (100%)	\$400	\$500	\$750
Accidental Dental	\$1,500 (100%)	\$1,500 (100%)	\$2,500	\$2,500	\$5,000
Medical Items	\$1,500	\$1,500	\$2,500	\$2,500	\$5,000
Medical Alert Bracelets	\$50	\$50	\$50	\$50	\$50
Emergency Transportation	Unlimited (100%)	Unlimited (100%)	Unlimited	Unlimited	Unlimited

**Maximums:** There is no lifetime maximum or overall annual plan maximum.

**Co-insurance:** Percentage the Insurer pays, subject to coverage maximums, applies to all categories of coverage unless otherwise specifically stated.

**Deductible:** There is no deductible.

**NOTE:** Stated maximums are per benefit year, unless otherwise specified, and apply to each plan member and insured dependant. Complete Form 2 included in this enrollment kit when applying for Optimum health plan.

† GUARANTEED - eligibility and open window conditions may apply

# DENTAL PLANS

Dental plans are available as an optional add-on to any health plan.

**Deductible:** There is no deductible.

**Co-insurance:** Percentage of an eligible claim the insurer pays.

**Fee Guide:** Coverage follows the current fee guide.

**Maximums:** Plan maximums stated below are per benefit year, unless otherwise specified and apply to each plan member and insured dependant.

## Overall Dental Plan Maximums

Year	Basic	Enhanced
Year 1	\$500 (70%)	\$700 (80%)
Year 2	\$750 (80%)	\$850 (80%)
Year 3+	\$1,000 (80%)	\$1,000 (80%)
Endodontic & Periodontal Services		
	50%	80%
Major Restorative Services		
Available ONLY after the 36th consecutive month of dental coverage		
	Not Included	50%

## Summary of Eligible Services

Eligible services include recall examinations once every 9 months, fillings, cleanings, scalings, examinations, polishing, extractions, general anesthetic and other standard services.

Endodontic treatment includes root canal therapy. Periodontal treatment includes addressing diseased bones and gums.

## Major Restorative Services

(Enhanced Dental Only)

Dentures include standard complete, immediate, transitional and partial dentures. Crowns include standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth.

Standard bridges, including pontics, abutment retainers/crowns (paid to full metal on molar) on natural teeth. Standard repair or re-cementing of crowns, onlays and bridge work on natural teeth.

# ADDITIONAL DETAILS

Further details to coverages listed on previous page.

## Prescription Drugs: (Pay Direct Drug Card system)

Benefits include drugs legally requiring a prescription, diabetic needles and syringes. Pay generic only unless otherwise indicated in the prescription. Benefits do not include smoking cessation products and medication for the treatment of obesity, erectile dysfunction and infertility.

**Travel Benefit:** Out of province/out of country emergency medical services up to 60 days for each trip; dollar maximum is per CALENDAR year regardless of the number of trips.

**Trip Cancellation:** Per covered person, per trip included in the overall maximum out of province/out of country.

**Hospital Accommodations:** Semi-private room in a public general hospital.

**Private Duty Nursing:** Services of an RN or RPN or LPN or PSW.

**Vision:** Maximums apply every 24 months based on date of first paid claim. Prescription eye glasses and/or contact lenses and/or laser eye surgery, eye exams (this benefit is only available for residents in provinces that do not cover eye exams under their provincial plan).

**Audio:** Hearing aids, repairs or replacement parts (maximums apply every 5 years based on date of first paid claim).

**Accidental Dental:** Accidental injury to natural teeth. Submit accident report immediately.

**Medical Items:** Includes items such as wheelchair, hospital bed, glucometer and lancets, orthotics, prosthetics, ventilator, pressure gradient stockings etc. Each individual item is scaled to usual customary limits.

**Emergency Transportation:** Land or air ambulance.

**Medical Alert Bracelets:** Maximums apply every 2 years based on date of first paid claim.

# Premium Guide

Rates are effective November 1st, 2023 for residents of Ontario

All rates listed are paid **monthly** and are inclusive of all taxes if applicable in your province of residence. Your coverage and your premium may be affected by changes in your family status. It is your sole responsibility to make Corsana Group Benefits aware of any such changes at the time of occurrence. Any premium paid towards coverage for which you were ineligible or which you no longer required as a result of non-contact at the time of the changes will not be refunded.

		Rates For Under 65				
		Essential	Essential Plus	Complete	Complete Plus	Optimum
Single	No Dental	\$81.65	\$110.54	\$127.24	\$202.80	\$127.24
	Basic Dental	\$134.24	\$162.76	\$179.46	\$260.12	\$179.46
	Enhanced Dental	\$154.87	\$184.19	\$199.49	\$277.14	\$199.49
Couple	No Dental	\$153.85	\$213.13	\$241.38	\$395.65	\$241.38
	Basic Dental	\$248.24	\$306.86	\$335.11	\$497.40	\$335.11
	Enhanced Dental	\$285.60	\$345.64	\$372.69	\$527.97	\$372.69
Family	No Dental	\$183.51	\$255.87	\$290.00	\$481.86	\$290.00
	Basic Dental	\$329.74	\$401.08	\$435.21	\$638.34	\$435.21
	Enhanced Dental	\$387.18	\$460.72	\$492.44	\$684.89	\$492.44

		Rates For 65+				
		Essential	Essential Plus	Complete	Complete Plus	Optimum
Single	No Dental	\$67.17	\$100.53	\$124.24	\$152.66	\$124.24
	Basic Dental	\$131.95	\$161.84	\$183.94	\$209.57	\$183.94
	Enhanced Dental	\$154.64	\$186.56	\$206.23	\$229.62	\$206.23
Couple	No Dental	\$132.42	\$196.23	\$241.72	\$294.54	\$241.72
	Basic Dental	\$248.84	\$306.96	\$351.20	\$398.64	\$351.20
	Enhanced Dental	\$288.00	\$349.27	\$392.46	\$437.58	\$392.46
Family	No Dental	\$142.34	\$219.04	\$272.73	\$335.69	\$272.73
	Basic Dental	\$320.46	\$387.76	\$442.78	\$496.85	\$442.78
	Enhanced Dental	\$381.44	\$454.20	\$507.89	\$557.12	\$507.89

# Premium Payment

A deposit and first month premium payment are required with each enrollment. Both payments are equal to the monthly premium for the plan into which you are enrolling.

Following your enrollment, ongoing monthly premium payments are made by pre-authorized, automatic debit from the chequing account of your choice.

The withdrawal will occur on the first of the month and funds are used to pay for your coverage for the following month.

## 1. Deposit Cheque

Your deposit cheque is to be dated the same as your enrollment forms and WILL be cashed when the enrollment forms are received. This cheque is **NOT VOID**.

The amount should be equal to the monthly premium for the plan into which you are enrolling. The amount will be held in trust for the duration of time you are covered under the Corsana Group Benefits plan and may be used to pay for your last month's premium should you choose to cancel OR may serve to ensure there is no disruption in your coverage should we not be able to collect payment from you in any given month - ie. insufficient funds.

PAY TO THE ORDER OF	Corsana Group Benefits	March 15, 2024	\$187.22
One Hundred & Eighty-Seven		22/100 DOLLARS	
FOR	Deposit	Jane Smith	

## 2. First Month Premium

Your first month premium cheque is to be dated for the first of the month in which your coverage will begin. This cheque is **NOT VOID**.

The amount should be equal to the monthly premium for the plan into which you are enrolling. This amount will be used to cover the cost of your first month of coverage under the plan.

Each monthly premium following your first month will be drawn from the same account on your last pay day each month and will cover the following month's coverage.

PAY TO THE ORDER OF	Corsana Group Benefits	April 1, 2024	\$187.22
One Hundred & Eighty-Seven		22/100 DOLLARS	
FOR	First Month Premium	Jane Smith	

## Don't Use Cheques?

We offer alternate solutions for making deposit and first month premium payments, ask an associate for more details. If paying your deposit and first month premium payment via an alternative method, please submit a pre-authorized debit banking form with your enrollment.



# Have Questions?

We're here to help! Our team can be reached Monday - Friday from 8:30 am - 4:30 pm.

**1032 Brock Street South  
Whitby, Ontario L1N 4L8**

Toll-Free: 1.855.267.7262

Local: 905.668.4050

[info@corsana.com](mailto:info@corsana.com)

**[www.corsana.com](http://www.corsana.com)**

**TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED**

## PART A - Contact Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Date Of Birth (MM/DD/YYYY): \_\_\_\_\_ Gender: ☐ Female ☐ Male

Street Address: \_\_\_\_\_

Apt: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law\*  
(See page 2)

I am covered under a provincial plan (i.e. OHIP): ☐ Yes ☐ No

## PART B - Employment/Association Details

### For Employees Of An Endorsing Organization Only

Date Hired (MM/DD/YYYY): \_\_\_\_\_ Occupation: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

### For Association Members Only

☐ Member of Association Date Joined (MM/DD/YYYY): \_\_\_\_\_

Association: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

## PART C - Enrollment Information for Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1 <sup>st</sup> Child:					
2 <sup>nd</sup> Child:					
3 <sup>rd</sup> Child:					
4 <sup>th</sup> Child:					

My dependants are covered under a provincial plan (i.e. OHIP): ☐ Yes ☐ No

## PART D - Coverage Information

Select Health Plan: ☐ Essential ☐ Essential Plus ☐ Complete ☐ Complete Plus

Select Dental Plan: ☐ No Dental ☐ Basic Dental ☐ Enhanced Dental

☐ I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)

## PART E - Declaration for Common-Law Coverage\*

I the undersigned, hereby certify that I have been living with \_\_\_\_\_ since (MM/DD/YYYY) \_\_\_\_\_ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

## PART F - Payment Information (Mandatory for All Enrollments)

Choose one method of payment for your deposit and first month premium:

☐ Pre-authorized debit (withdrawal from a chequing account)

We require **two cheques (NOT void)** to be submitted with your enrollment and both must be made payable to **Corsana Group Benefits**.

☐ E-transfer (Corsana will reach out to confirm e-transfer details)

☐ Credit Card ☐ Mastercard ☐ Visa

Name (as it appears on card): \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

**If paying deposit and first month premium by e-transfer or credit card, please attach a void cheque or pre-authorized debit form from your financial institution to your application. \*Your account must have chequing privileges.\***

**I hereby authorize Corsana Group Benefits to arrange automatic deductions from the account provided.**

**Dated** \_\_\_\_\_ **this** \_\_\_\_\_ **day of** \_\_\_\_\_ **20** \_\_\_\_\_

(City/Town) (Day) (Month) (Year)

**Signature of Employee:** \_\_\_\_\_

## PART G - Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Corsana Group Benefits for which I am eligible, and I authorize the association/organization to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependants must be covered under a provincial health plan and that I (retirees excluded) must be actively working in order to be eligible for coverage. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependants for whom coverage is sought. I understand that Corsana Group Benefits reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Corsana Group Benefits of any changes in my status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

**Date (MM/DD/YYYY):** \_\_\_\_\_ **Signature of Enrollee:** \_\_\_\_\_

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Corsana Group Benefits is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

# STATEMENT OF HEALTH OPTIMUM COVERAGE

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## PART A - General Information (Employee and Dependants)

Please complete the following information for all persons eligible for coverage including yourself, your spouse and all eligible dependants.

Relationship:	Name (First, Last):	Date Of Birth (MM/DD/YYYY):	Height (Ft/In):	Weight (lbs):	Smoker (Y/N):
Employee:					
Spouse:					
1 <sup>st</sup> Child:					
2 <sup>nd</sup> Child:					
3 <sup>rd</sup> Child:					

## PART B - Statement of Health Questionnaire

Have you or any of your dependants ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy, naturopathy, etc.) about, been treated for, or had any known indication of any of the following: Yes No

1. Anxiety, depression, insomnia, ADD/ADHD, eating disorders or any other emotional, mood, behavioural or mental health disorders		
2. Alzheimer's disease, dementia, Parkinson's disease, seizures/epilepsy, loss of consciousness, multiple sclerosis, paralysis or any other neurological disorders		
3. Kidney stones, kidney disease, interstitial cystitis, benign prostatic hyperplasia (BPH) or any other kidney, bladder or prostate disorders		
4. Liver disorders, including hepatitis		
5. Infertility, ovarian cyst, PCOS, uterine fibroids, irregular menses, menopause or any other reproductive or breast disorders		
6. Crohn's disease, ulcerative colitis, irritable bowel syndrome, ulcer, hernia, persistent heartburn/reflux or any other gastrointestinal disorders		
7. Heart disease, stroke/TIA (mini-stroke), heart attack, irregular heartbeat, angina, high blood pressure, elevated cholesterol or any other circulatory, heart or vascular disorders		
8. Alcoholism or drug dependency		
9. Skin disorders, including acne, rosacea, psoriasis or eczema		
10. HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders		
11. Arthritis, osteoporosis/osteopenia, back pain, joint pain, muscle pain, fibromyalgia or any other joint, bone or muscular disorders		
12. Allergies, asthma, COPD, chronic bronchitis, emphysema or any other respiratory, sleep apnea or lung disorders		
13. Chronic headaches or migraines		
14. Basal cell carcinoma, growths, polyps, tumors, leukemia or any other cancers		
15. Cold sores, herpes or any other sexually transmitted diseases or infections (STDs or STIs)		
16. Diabetes/elevated glucose, hypothyroidism, hyperthyroidism, adrenal fatigue or any other endocrine, hormonal or thyroid disorders		
17. Glaucoma, cataracts, Meniere's disease or any other eye, ear or balance disorders		
18. Anemia or blood disorder		
19. Any other condition, disease, disorder or injury not listed above		
20. Have you or any of your dependants ever been treated or hospitalized for or had any known indication or any physical impairment, condition, disease or disorder not stated above?		
21. Are you or any of your dependants currently taking prescription or non-prescription medications of any kind or been advised by a physician or alternative health care provider to take medication of any kind?		
22. Have you or any of your dependants ever been advised to have an investigation, hospitalization or surgery which has not yet been completed?		
23. Have you, your spouse or any listed dependant children been hospitalized in the last 2 years?		

**If you answered yes to any of the questions above, please provide additional details on the overpage, and circle which diagnosis or disorder applies to you or your dependants.**



# STATEMENT OF HEALTH OPTIMUM COVERAGE

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## PART C - Further Information Regarding Conditions From Overpage

If you answered yes to any of the questions on the overpage, please fill out the further details in the fields below and indicate the corresponding question number.

Question Number:	Name of Employee/Dependant (First, Last):	Nature of Illness, Injury or Condition:	Date of Onset & Recovery (MM/DD/YYYY):	Type of Medication (DIN) or Treatment:	Approx. Monthly Cost of Medication:	How Often Do You See Your Doctor For Treatment:

Please note that based on your medical history, or that of a listed dependant, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the enrollment which this statement of health is a part of or acceptance of a counter offer.

## PART D - Enrollee Declaration

I hereby declare that all the statements contained in this application for the Corsana Group Benefits are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility, or organization which has records of my or my dependants health to release such information to the plan administrator. I understand and agree that the information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand that it is my obligation to inform Corsana Group Benefits of a change in my health or that of my spouse or any listed dependant children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Corsana Group Benefits reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Corsana Group Benefits reserves the right to audit claims. **This form is valid ONLY 30 days from the date it is signed.**

Dated \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
(City/Town) (Day) (Month) (Year)

Signature of Enrollee: \_\_\_\_\_

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Corsana Group Benefits is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.